CODE	Section II-A COST REPORTING/ADJUSTED COMMUNITY RATE	YES	NO	NOTE
	COST-BASED CONTRACTORS ONLY - COST REPORTING AND PAYMENT			
CR01	**The MCO's cost report and the methodology used to develop it, meet all applicable Federal requirements, as verified by qualified auditors.** **42 CFR Part 417 Subpart O:42 CFR 417.568(a)(1); 42 CFR 417.556(d); 42 CFR 417.568(b)(1); 42 CFR 417.568 (b)(2).** **[ ] NOT APPLICABLE [ ] MET [ ] NOT MET**			
MOE	MCOs holding §1876 cost and §1833 cost contracts are required to submit cost reports at least annually to the Health Care Financing Administration. At the time that these reports are submitted to the HCFA, qualified auditors review these reports, along with related methodologies, to determine: (1) the MCO maintains sufficient financial records and statistical data for proper determination of costs payable by Medicare; (2) the MCO's cost report provides adequate cost and statistical data based on its financial records that can be verified; (3) the cost data are based on an approved method of a cost finding and on the accrual basis of accounting; and (4) the MCO has an effective system capable of detecting under-utilization or under-referral of medically necessary services by health plan physicians. MCOs that meet these requirements at the time the annual cost report is reviewed meet the requirements of CR01. Under normal circumstances, the reviewer is not responsible for verifying that the MCO meets the above requirements at the time of the monitoring visit. An operating presumption is that MCOs that would not meet the aforementioned requirements would not be permitted to continue contracting with the HCFA for the provision of Medicare services. Certain circumstances may dictate that a reviewer check to confirm that the MCO continues to meet all applicable Federal regulatory requirements to complete this section of the review guide. If necessary, for cost-based contracts, the Central Office plan manager should check with the Office of Financial Management specialist who reviewed the MCOs annual cost report submittal.			
CR02	**<u>FOR HEALTH CARE PREPAYMENT PLANS ONLY</u>: The MCO is subject to the limitations of subpart E.** **42 CFR 417 Subpart U: 417.802(b)(2)(ii)(A)** **[ ] NOT APPLICABLE [ ] MET [ ] NOT MET**			
MOE	An MCO that requests approval of an effective incentives waiver (i.e., an exception to the Medicare physician fee schedule limitations) is subject to subpart E limitations. As stated in 42 CFR 417.802, to qualify for this exception, an HCPP that reimburses its physician group(s) on a fee-for-service basis must demonstrate that 1) it has arrangements with a "physician group organized on an individual practice basis" and 2) the group "has procedures under which the members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services." Individual direct-contract physicians who are reimbursed on a fee-for-service basis are limited to the Medicare reasonable charge.			

MOE con't.	MCOs that request an effective incentives waiver must do so annually. When applicable, the reviewer must confirm that the Central Office plan manager has reviewed and approved this waiver request annually. An MCO that applies for the effective incentives waiver (at least annually) and demonstrates that it meets the requirements for element CR02. An MCO that has not received such approval annually does not meet the requirements for CR02.			
RISK-BASED CONTRACTORS ONLY - ADJUSTED COMMUNITY RATE (ACR) DATA REVIEW				
AC01	**The MCO properly calculates its ACR, utilizing methodology that meets all applicable Federal requirements. 42 CFR Part 417 Subpart P: 417.594(a)(1) and (2); 42 CFR 417.594(b)(1)(I) and (ii); 42 CFR 417.594(b)(2); 42 CFR 417.594(c) [ ] NOT APPLICABLE [ ] MET [ ] NOT MET**			
MOE	Review of these regulatory requirements is conducted by the HCFA's ACR auditors. MCOs with Medicare risk-based contracts must annually submit an adjusted community rate (ACR) proposal to the HCFA. In order for HCFA to approve an ACR proposal, an MCO must demonstrate the following: (1) The MCO calculates separate ACRs for Part A and Part B enrollees and Part B-only enrollees; (2) the ACR computation accounts for anticipated revenue from primary payers for services for which Medicare is not the primary payer; (3) the MCO has calculated its initial rate using a community rating system or aggregate premium for all its enrollees that is weighted by the size of the various enrolled groups; (4) the MCO's initial rate equals the premium the organization would charge its non-Medicare enrollees for the Medicare-covered services; and (5) the MCO's adjustment factors reflect the utilization characteristics of the organization's Medicare enrollees. Under normal circumstances, the reviewer will not need to verify that the aforementioned regulatory requirements relative to the ACR proposal have been met; an operating presumption is that MCOs that do not meet these requirements would not receive approval of their ACR from HCFA. MCOs that receive annual approval of their ACR proposal meet the requirements for element AC01. However, the reviewer should review both the current-year approved ACR along with the Benefit Information Form (BIF) prior to initiating the monitoring review. Knowledge of this information may prove helpful to the reviewer in conducting other parts of the monitoring review (e.g., determining if the MCO offers its ACR - approved benefit package to all eligible Medicare enrollees.)			